(i) Promptly and without undue delay, send written notice to the applicant or enrollee informing the appellant:

(A) That the appeal request has not been accepted;

(B) About the nature of the defect in the appeal request; and

(C) That the applicant or enrollee may cure the defect and resubmit the appeal request by the date determined under paragraph (b) or (c) of this section, as applicable, or within a reasonable timeframe established by the appeals entity.

(ii) Treat as valid an amended appeal request that meets the requirements of this section and §155.505(b).

(3) Upon receipt of a valid appeal request pursuant to paragraph (b) of this section, or upon receipt of the notice under paragraph (d)(1)(ii) of this section, the Exchange must transmit via secure electronic interface to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the Exchange; and

(ii) The appellant's eligibility record.

(4) Upon receipt of the notice pursuant to paragraph (d)(1)(iii) of this section, the State Exchange appeals entity must transmit via secure electronic interface the appellant's appeal record, including the appellant's eligibility record as received from the Exchange, to the HHS appeals entity.

§155.525 Eligibility pending appeal.

(a) *General standards.* After receipt of a valid appeal request or notice under §155.520(d)(1)(ii) that concerns an appeal of a redetermination under §155.330(e) or §155.335(h), the Exchange or the Medicaid or CHIP agency, as applicable, must continue to consider the appellant eligible while the appeal is pending in accordance with standards set forth in paragraph (b) of this section or as determined by the Medicaid or CHIP agency consistent with 42 CFR parts 435 and 457, as applicable.

(b) *Implementation.* If the tax filer or appellant, as applicable, accepts eligibility pending an appeal, the Exchange must continue the appellant's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

§155.530 Dismissals.

(a) *Dismissal of appeal.* The appeals entity must dismiss an appeal if the appellant—

(1) Withdraws the appeal request in writing or by telephone, if the appeals entity is capable of accepting telephonic withdrawals.

(i) Accepting telephonic withdrawals means the appeals entity—

(A) Records in full the appellant's statement and telephonic signature made under penalty of perjury; and

(B) Provides a written confirmation to the appellant documenting the telephonic interaction.

(ii) [Reserved]

(2) Fails to appear at a scheduled hearing without good cause;

(3) Fails to submit a valid appeal request as specified in §155.520(a)(4); or

(4) Dies while the appeal is pending.

(b) *Notice of dismissal to the appellant.* If an appeal is dismissed under paragraph (a) of this section, the appeals entity must provide timely written notice to the appellant, including—

(1) The reason for dismissal;

(2) An explanation of the dismissal's effect on the appellant's eligibility; and

(3) An explanation of how the appellant may show good cause why the dismissal should be vacated in accordance with paragraph (d) of this section.

(c) *Notice of the dismissal to the Exchange, Medicaid, and CHIP.* If an appeal is dismissed under paragraph (a) of this section, the appeals entity must provide timely notice to the Exchange, and to the agency administering Medicaid or CHIP, as applicable, including instruction regarding—

(1) The eligibility determination to implement; and

(2) Discontinuing eligibility provided under §155.525, if applicable.

(d) *Vacating a dismissal.* The appeals entity must—

(1) Vacate a dismissal and proceed with the appeal if the appellant makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated; and

(2) Provide timely written notice of the denial of a request to vacate a dismissal to the appellant, if the request is denied.

[78 FR 54136, Aug. 30, 2013, as amended at 79 FR 30349, May 27, 2014]

§ 155.535 Informal resolution and hearing requirements.

(a) *Informal resolution.* The HHS appeals process will provide an opportunity for informal resolution and a hearing in accordance with the requirements of this section. A State Exchange appeals entity may also provide an informal resolution process prior to a hearing, provided that—

(1) The process complies with the scope of review specified in paragraph (e) of this section;

(2) The appellant's right to a hearing is preserved in any case in which the appellant remains dissatisfied with the outcome of the informal resolution process;

(3) If the appeal advances to hearing, the appellant is not asked to provide duplicative information or documentation that he or she previously provided during the application or informal resolution process; and

(4) If the appeal does not advance to hearing, the informal resolution decision is final and binding.

(b) *Notice of hearing.* When a hearing is scheduled, the appeals entity must send written notice to the appellant of the date, time, and location or format of the hearing no later than 15 days prior to the hearing date.

(c) *Conducting the hearing.* All hearings under this subpart must be conducted—

(1) At a reasonable date, time, and location or format;

(2) After notice of the hearing, pursuant to paragraph (b) of this section;

(3) As an evidentiary hearing, consistent with paragraph (e) of this section; and

(4) By one or more impartial officials who have not been directly involved in the eligibility determination or any prior Exchange appeal decisions in the same matter.

(d) *Procedural rights of an appellant.* The appeals entity must provide the appellant with the opportunity to—

(1) Review his or her appeal record, including all documents and records to be used by the appeals entity at the hearing, at a reasonable time before the date of the hearing as well as during the hearing;

(2) Bring witnesses to testify;

(3) Establish all relevant facts and circumstances;

(4) Present an argument without undue interference; and

(5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

(e) *Information and evidence to be considered.* The appeals entity must consider the information used to determine the appellant's eligibility as well as any additional relevant evidence presented during the course of the appeals process, including at the hearing.

(f) *Standard of review.* The appeals entity will review the appeal *de novo* and will consider all relevant facts and evidence adduced during the appeals process.

§ 155.540 Expedited appeals.

(a) *Expedited appeals.* The appeals entity must establish and maintain an expedited appeals process for an appellant to request an expedited process where there is an immediate need for health services because a standard appeal could jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.

(b) *Denial of a request for expedited appeal.* If the appeals entity denies a request for an expedited appeal, it must—

(1) Handle the appeal request under the standard process and issue the appeal decision in accordance with § 155.545(b)(1); and

(2) Inform the appellant, promptly and without undue delay, through electronic or oral notification, if possible, of the denial and, if notification is oral, follow up with the appellant by written notice, within the timeframe established by the Secretary. Written notice of the denial must include—

(i) The reason for the denial;

(ii) An explanation that the appeal request will be transferred to the standard process; and

(iii) An explanation of the appellant's rights under the standard process.